MENTAL HEALTH SERVICES ACT (MHSA)
Stakeholders Meeting
December 17, 2004

Attachment 2 – More Thoughts

These comments, handwritten or emailed after the meeting, were submitted by a large number of participants. Since several sheets contain comments in more than one person's handwriting, it is hard to assess how many individual participants submitted comments in this format. As with the other forms of feedback, the topics covered include the vision statement, components of the workplan, involvement of consumers, families and other stakeholders, the role of the state, whether funding should be released for planning on January 1 or wait for approved plans, and mechanics of the stakeholder process and meeting. Please note that the numbers in parentheses denote the number of responses in each category or the number of times the same comment was made. There were a total of 121 comments in this format.

Vision Statement (8)

- Include language on dual diagnosis: it does not mean just substance abuse – it can also mean physical and other disabilities and homelessness.
- In addition to reducing adverse impact of untreated mental illness, reduce the negative impact of mental health treatment (i.e., abuse, rights violations, medication side effects, malpractice, etc.).
- In the President's New Freedom Report, special emphasis was placed on providing services so that clients can receive services "in the community." We should include a statement that we are committed to keeping and serving clients in their community.
- Clients as decision-makers language needs to be added. There is no mention of support for advocacy services mentioned.
- You mention transition services for youth, but none for adult to older adult. Clients start having physical problems around age 50-55.
- Tie accountability to values and principle of mission statement to funding and oversight. Failure of a county to demonstrate measurable outcomes of accountability to consumers and family members. Failure to do so means loss of funds.
- You must address the issue of criminalization of the mentally ill. It is notably absent from the mission statement.
- Purpose is to keep people off the street and out of hospital.

Components of the Workplan (40)

Local Planning (9)

- Each county needs to do its own thing – contact director to include all involved with mental health.

- If required by limited funds, can a county roll out its system of care planning components such that the "adult SOC" planning could be completed by 6/30/05, for instance, and that plan component submitted to DMH for approval separately from children's SOC and older adults SOC plans? This would allow counties to spread planning costs over two fiscal years (2004-05 and 2005-06). Were this whole process to start in July 2005, counties would have a full year of tax revenue (at 5%) for planning and could front-load costs to the first six months. Since we have a mid-year start, the only recourse is to spread planning activities and costs across the fiscal years, delaying some SOC planning until after 7/1/05. The SOC plans represent the bulk of planning costs. The key question is whether DMH will allow counties to manage costs by accepting specific SOC plans separately from the others for approval and funding.
- Need to front-load funds for local county planning to ensure that the planning process achieves the standards and purpose:
    - Adequate staffing
    - Consulting for content expertise
    - Stakeholders participation and staff costs may not be easily "staggered" Gearing up for planning will require high start-up costs
    - Media and publicity costs will be largest at start of planning process
    - Momentum of early stakeholder participation must be maintained and supported. This will require staff, organization, facilitation
- The cost-effectiveness of planning will result from the effectiveness of the eventual programs and not the cost of planning.
- Force counties to bid out services that they provide or want to provide, if there is really a concern for cost-effectiveness and openness to different approaches.
- Hold different focus groups in the community. For example, San Francisco has five threshold languages that people or clients speak. The county has been holding a number of focus groups to get the clients' ideas and thoughts to develop the best quality of mental health and substance abuse services in the San Francisco Behavioral Health Services.
- The fastest input is survey to community at large. Survey forms with deadlines such as consumer survey.
- Plans need to be consistent with other county plans and endeavors.
- Planning grants should be $75,000 base grant, plus additional amount 200% of need (Medi-Cal, working poor, with census data determining prevalence). Add a factor for ethnicity for underserved.

Systems of Care (18)

Services/Programs (8)

- Services to "underserved" should be a feature of the "systems of care" plans, rather than groups with "prevention and early intervention."
- Please work to shut down state hospitals.
- Better teamwork with juvenile and adult justice systems, education, medical providers, non-profits, using multidisciplinary teams and case work approach.
- Orange County has an effective diversion program with mental health courts. This would be a good model throughout the state.

- Need to include as partners community organizations in service delivery continuum. Also, look at eliminating duplication of services between programs.
- Systems of care and bridge programs are successful yet funding was eliminated. Glad to see emphasis on each in state guidelines. I hope each local plan requires these to continue.
- Focus on co-occurring disabilities specific to teens and aftercare self-help development (Adult AA and Alateen doesn't work for teens with AOD problems).
- LA has a public private partners program with primary health care clinics. Mental health services are a part of many clinics' provided services. Inclusion of clinics should be mandated at state level so counties "listen and work with" these collaborative partners. Services are cost-effective and linguistically and culturally sensitive. Outcomes are recorded currently. The system works.

Support/Alternative Services/Housing (7)

- I would hope MHSA funds could be used to create crisis houses that would be a more cost-effective alternative to psychiatric emergency rooms and hospitals.
- Use agencies such as therapeutic recreation services in mental health and community-based leisure and park services.
- Devise consumer driven programs rather than clinician driven therapeutic recovery setting center.
- Create credit cards that registered clients can use to select and pay for services. The credit slips will be routed to a state-funded organization for approval and reimbursement. A list of certified services would be created with ongoing client input. An ombudsperson position can be created to handle complaints from service providers and clients.
- We need a "passport" so that eligible individuals can access services in any county.
- In our county, mental health staff frequently state that it is not a good thing to create a system that is too user-friendly, too welcoming, because of our severe financial situation. Would a "passport" system help to alleviate the pressure of that counties that are too welcoming? And is this attitude one that will undermine the entire goal of Prop 63?
- There needs to be more counseling and housing support for mental health clients who are mothers or fathers who have had their kids taken away from them. Care should be given that many of these mothers often lose TANF and become homeless, thus becoming doubly traumatized. CPS staff should be sensitive to this situation, help maintain housing, get counseling support.

Children's System of Care (3)

- Provide for more inclusion of the preK-12 public education system – more than special ed. Ensure they are a mandated partner in the children's system of care.
- Plan for an inter-county integrated system of care for foster and foster-adopt children to easily access services in the county in which they reside.
- Provide respite for families and foster parents struggling to raise severely emotionally disturbed children.

Capital Facilities and Information Technology (1)

- Consider internet access for clients at county mental health centers and wiring drop-in centers and providing computers there

Prevention and Early Intervention (4)

- Some prevention funds should be used for research.
- Prevention and Early Intervention: We need to find ways to serve those in the senior population who have developed dementia who also are exhibiting psychotic symptoms to receive appropriate care before crisis occurs. This is a very small component of those with dementia, but they often fall between the cracks until very severe consequences occur.
- Prevent trauma in children's lives and in elderly lives. Provide help first in small ways to maintain stable care and love.
- Since 85% of people diagnosed with chronic mental illness report abuse (per NASMHPD), prevention should include education about domestic violence and sexual abuse.

Training and Education Workforce Development (9)

- Case managers, social workers and psychologists – level of training required
- Designate funding to support medical education to address serious shortage of practitioners, i.e., child psychiatrist to serve underserved patient population.
- All health care providers (PCPs, etc.) will be educated on needs of mental health consumers and resources available for meeting those needs, to reduce stigma.
- Recognizing that the primary resource for identifying, preventing, evaluating and treating people with mental illness is the person providing care, education will be enhanced for all levels of care provision.
- Ensure qualified, competent employees.
- Set up a process to make sure that the training is directed to providing neutral background and not influenced by any certain direction, philosophy, program, methodology.
- Train advocates thoroughly on the system of care so they feel empowered to make change.
- Hold a Mental Health Initiative Fair Day for each county to draw in the homeless and underserved where consumers are drawn into learning what services will be available to them and what community resources are available at the same time. This will draw in those people needing services who do not reach out for help due to stigma, discrimination or victimization.
- Add to Attachment C, "E": South San Joaquin Valley counties need extra training because the new hospital in Coalinga that will serve the SVP population will deplete a large percentage of providers from Kern through Stanislaus counties.

Stakeholders (37)

Consumer and Family Involvement (26)

Cultural/Linguistic/Other Eligibility Issues (9)

- Ethnic communities may find it awkward to speak up at large group meetings. Stakeholders from ethnic communities may be more comfortable in small groups with bilingual or interpretive assistance.
- Expand the diagnoses included in the target population.
- Be aware of potential for limits in access due to cultural issues, language, transportation, etc. Consider using CBOs and alternative meeting strategies to address these issues. Develop locally appropriate strategies to address this issue.
- How will adults who cannot take care of their needs but do not believe they are sick be helped by this initiative? My mother was in her 40's when she got sick, diagnosed with paranoid schizophrenia when she was 49. She had a job, a house, and people who loved her. She became homeless in 1988 and has remained so. She had money from the sale of her home. She doesn't think she's sick. Now what? In 16 years on the streets, she is killing herself. The "system" has refused to help her. That needs to change. She deserved a better life.
- Poverty focus of mental health money and services: with children, is that appropriate?
- Don't forget people who are not poor and people who have health insurance. Medi-Cal providers are often not very good at their jobs. Pay more and require less paperwork from good doctors.
- Are there resident requirements? Portability of services between counties required a mandate from DMH.
- There was no discussion regarding mental health services for undocumented clients. Would the State approve plans that targeted undocumented and uninsured consumers? For example, 0-5 year old consumers are often underserved in the mental health system. Undocumented consumers should be added to the stakeholders list.
- Include middle class families whose insurance may not include comprehensive mental health services.

Participation in Planning Process (9)

- "Nothing about us without us." (CNMHC) Offering stipends to consumers who share their knowledge and recovery experiences to improve the quality of mental health and substance abuse services. Recovering clients feel worth and gain self-esteem by earning stipends through sharing their recovery experiences.
- In LA today, the County is holding a one time meeting for stakeholders to give input on future programs. This is not allowing for complete stakeholder participation.
- Consumer sessions should be at times that consumers are not working. Many work in the fields from sun up to sundown and can't make a meeting in the middle of the day. Some counties take this direction so they don't receive input.
- State should use statewide consumer groups to assist counties that do not have established consumer groups. Counties must invite these groups in if they can't provide client feedback.

- Go to consumers in IMDs and state hospitals for feedback.
- I am concerned about the need for oversight by clients, consumers, survivors, inpatients, and ex-patients, at the level of county and city mental health departments. It's not happening at this meeting by a long shot. The language of the MHSA is supposed to empower clients to have a voice in this process, but the way this meeting was organized undermined any change for true inclusion of the vast majority of clients or accountability to our grassroots constituency. Specifically, clients who are homeless, do not speak English as a first language, live in an institutional setting, work during the week at non-mental health-related jobs, are not able to read or write or access the internet were systematically excluded from this meeting. This is the vast majority of my friends, and it included me up to a few years ago. To make this process inclusive, clients must be paid to do grassroots outreach on the streets and in the institutions. This is the only way we will reach Prop 63's intended beneficiaries and those who can and should be empowered as leaders in innovative services.
- I did not want to bring this up at the meeting, but there are some consumers, including me, who because of our age and being on medication, cannot use a computer and access the web or use email. I went to a community college for five years to learn how to use a computer, and I did purchase one. When I got the computer home, I could not figure out how to hook it up and living in a small town in a rural county, I could not find anyone who could hook it up for me even if I paid them. My only means of communication is by fax or regular mail. Thank you.
- Consumers should be required to be reimbursed or given an incentive.
- Outreach must be done to reach those who "cannot attend usual meetings, i.e., those in jails, prisons, IMDs, state hospitals and others who have a lower recovery level."

Participation in the Implementation Process/Leadership Development (5)

- Through Prop 63, this is the precious opportunity to establish good client relations and good bonding. Use different backgrounds and disorders of clients to build leadership. San Francisco has been developing the Asian American Consumer Leadership Project. I hope to develop a similar one for the African American and Latino communities in the coming year. If Prop 63 could allocate budget for consumer leadership building in local or regional level, more and more recovering mental health and substance abuse consumers will have successful wellness and recovery experiences.
- More parent partners required for each county's children's system of care.
- More parent partners required for each county's wraparound services.
- Clients and former clients should be given seniority in new hiring using Prop 63 funds, not degreed or certified providers. These jobs can be stepping stones to other non-mental health work. This principle should be recommended to all counties.
- Clients should be given access to their clinical records and allowed to make entries in the record. This step can be recommended to all counties.

Advocacy (3)

- CNMHC may be the voice of the clients, but they may not be truly representative.
- Peer and self-advocacy programs of protection and advocacy would love subsidy support to inreach in locked mental health facilities and for community client empowerment.
- Also support for developmentally disabled peer unit support for PAI.

Other Stakeholder Involvement (11)

- Primary care providers (especially those in clinics already providing mental health or integrated behavioral health) are the only prescribing workforce already in place that is large enough to deliver prevention and early intervention care – now. Make them full partners, please. Begin training them now on a statewide basis.
- How do you ensure that non-profit organizations and health centers obtain their fair share of funding for mental health services? Traditionally, many counties have been reluctant to contract with them.
- I am really concerned that there is no assurance that K-12 is involved in the conversation. There are thousands of PPS credentialed people in schools who have serious concerns regarding students in need. Students are suicidal, depressed, have eating disorders and alcohol and drug addictions. PPS credentialed staff know where their training requires a referral. The problem is there is no mechanism by which to do this and not enough services for those in need. Our students wait months for help. For example, suicidal student put in hold and then released to parents to return to school without any ongoing assistance. Parents have no money for therapy and don't qualify for Medi-Cal. In addition, schools will need funding to ensure systems are in place designed to 1) educate schools on mental health issues; 2) design referral processes and procedures; 3) train PPS on appropriate referral needs; and 4) ensure transition into and out of schools for services.
- We at SEIU feel that direct service workers involvement in the stakeholder planning process is crucial to the development of an effective plan in each county. We appreciate the acknowledgement of workers at all levels in the various attachments. We request that you add both "labor" and "direct service workers" to the table on Page 5 of Attachment C.
- Getting the unions as formal full partner stakeholders will increase the speed of mental health workers' buy-in and increase the progress of the program. Worker input may be valuable in how to implement the process towards the programmatic outcome.
- Ensure labor has a voice.
- How is the federal government involved in the MHSA?
- The general public voted in MHSA; we owe them feedback – they deserve to know what is going on, as well as professionals. Are we educating the general public and the media in the first year to re-imagine people with psychosocial disabilities and reduce prejudice and discrimination?
- Add patient rights advocates.
- Add independent living centers and cross-disability groups.
- Providers and contractors deliver more than half the services in California. They need to be names stakeholders on the list of stakeholders and assumed to be full

partners in the process along with other important stakeholders. Effective implementation and service delivery will depend on the input of the providers who will actually implement and deliver the services. They are not simply mindless extensions of the county.

Role of State (5)

- DMH needs to develop some criteria of plans requiring consistency for counties, based on stakeholder information.
- How can we ensure that counties will not use these new funds to backfill old system that are being cut in the current budgetary crisis? Who will monitor and how?
- There must be a standard requirement pertaining to outreach, training access and transportation, children, food, lodging and consumer involvement to the table so their voices can be heard. Without this funding requirement, consumers will not be able to participate at all levels of the MHSA process.
- Many counties have already begun the planning process. Some have included stakeholders in their process, others have not. The SMH needs to establish a mechanism to ensure accountability at the county level. For example the statewide review should include an open public comment period so stakeholders can express concerns with the local plan process and counties can be held accountable for broad input at the local level.
- The State should provide more leadership in how the counties are to carry out their stakeholder processes. Important stakeholders should be full partners unless the county can convince the stat that this is not necessary.

Funding by January 1 (9)

Yes (3)

- Counties should be allowed to spend some percentage of the base allocation prior to approval of the plan.
- I think SDMH should allocate the $75,000 to the counties effective January 1, but I would not recommend a full allocation until you approve the county plan and budget request. I'm concerned that some counties will use any up front planning monies to beef up their planning staff before assessing their planning needs and the breadth of activity necessary in order to meet the mandates in the SDMH guidelines. Also, once the plans are approved there needs to be a feedback loop/follow-up visits or focus group meetings with stakeholders to be certain that counties are following through with opportunities to make sure stakeholders are being heard.
- Provide $75,000 to county mental health services prior to, not after, planning of pre-planning process – by January 1, 2005.

No (6)

- Hold on to the funds for services until July 1, 2005 and start a trust fund to pay for longer term intensive care. The proceeds from the fund can be used for the most expensive care, upon application by a county. However, when a county “overused: the fund, a quality improvement group must be formed and sent to the county to revise procedures in ways that will promote more cost-effective care.

- Wait and be assured counties will be working with an approved plan and in full knowledge of what each stakeholder is capable of or already doing. Standardize dialogues and be sure county systems will be able to inter-refer between counties and support and integrate with key stakeholders for core services across the state.
- Keep the money until the plans are ready.
- If no approved plan, how can local mental health plans know that they are on track or not?
- It is impossible to ask people if they want to get the money first, when it is clear they do not know what they are saying yes to or the consequences.
- Counties should not be given any funds until they have an approved plan.

Stakeholder Process (6)

- When hiring a facilitator for this process, please consider using both a state-selected facilitator and a consumer facilitator selected by the CNHMC.
- Stakeholder process should include regional meetings, workshop format, longer meeting time (this meeting should have started at 9 am). Once you knew there were more than 500, you should have scheduled a second meeting (easier said than done, however)
- I think SDMH should hold its meetings monthly in Sacramento; video conferencing could be made available for each county so people who can't make the trip (line staff) would be able to take part in the discussions. I think consistency in meeting place (Sacramento) is important symbolically. Having a central point for information exchange and a vortex for decision making is especially important during this very critical planning phase when standards and guidelines are being established and short turnarounds are essential. Having the meetings in Sacramento also helps stakeholders establish relations with the reps from statewide organizations (like UACC, CCCMHA, Planning Council and NIMH) who will be critical players in offering technical assistance and follow-up conversations between meetings.
- That's all I have for now. I agree that we can be a model for the country but only through the successes of our modeling here at home. This was a very effective meeting and I look forward to viewing the website.
- This forum should be duplicated at local levels. Perhaps you can give us the format and slides to present at local levels to communities.
- Use virtual regional teleconference and smaller regional meetings. This large process was fabulous. However 600 person public input process is inefficient. The State must actually work with local leaders, i.e., mental health providers, Mental Health Boards, client and family member networks to hold regional meetings. You can use technology by holding interactive teleconferencing. This would be labor-intensive, but would eliminate the problem of timing and would be inclusive. The example used for this was Behavioral Health Courts (San Francisco – 415-255-3473), Medi-Cal Redesign or CSAC.

Stakeholder Meeting Process (5)

- This has been awful: too loud, confusing and divisive.
- I attended the Stakeholders Meeting at the Elks Club on Friday and want to thank you for your openness regarding the magnitude of our challenges and the need to work together to fulfill our vision in a transparent manner. Modeling the stakeholder process is an excellent idea and I hope the counties follow by example. I think counties should be required to develop their own MHSA interactive website. What a cost-effective way to keep local stakeholders connected! A number of consumers expressed a desire for receiving information in plenty of time before each meeting so they can ask clarifying questions. It's also nice to share feedback and concerns when one cannot be present to see if others have the same issues. The easiest way to devalue someone's input is by not giving him time to make a meaningful contribution.
- Thank you very much for this forum. It is very much needed and appreciated.
- Today's meeting: I think the person typing needs to accurately reflect what the person is saying. I noticed things were left out in the note-typing.
- I thought the meeting was extremely well-run, considering the size of the group.

Other (11)

- Insurance for the working families to take care of a health problem is a smaller curable problem. Good nutrition problem solved by the county and US government programs. Provide community centers that include all populations.
- In Berkeley, homeless advocate Michael Diehl convinced the Mayor to sleep outside. Perhaps Governor Schwarzenegger could be induced to try it in order to get a sense of what the homeless mentally ill encounter.
- In regard to the funding, I understand some counties are fearful that because of the apparent non-categorical nature of these funds, Boards of Supervisors, heads of Health Authorities and Health Departments and County Administrators may feel justified in establishing local control over these dollars. I think you responded to a question related to this issue by referring to how historically funds have flowed through County Mental Health. I suggest you make reference to statute (regulation) as it relates to MHSA so there is no misunderstanding in this regard. You recall the comment about the misuse of Prop 10 dollars. It's going to be hard enough to protect against supplantation and I think we will be inviting disaster if we allow the management of these funds to rest with any public entity other than County Mental Health. In regard to the formula for allocating planning dollars, the folks at our table supported the "number of uninsured" in the county as the primary determinant. By doing so we bring more of the working poor and undocumented populations into the calculation who are certainly target groups who are underserved in our system.
- Assure that each government entity be required to maintain a maintenance of effort so that MHSA does not supplant existing service funding.
- Many folks are selected into mental health service by force and/or coercion. Providers argue they are most severely disturbed. Representatives of care feel they have no need of care – they are incarcerated, conscripted into mental health populations.

- There needs to be glossary of clearly defined terms.
- Need clear definitions of serious mental illness – by whose standards? Do we need proof or certification? Signed by whom?
- The target population has shrunk along with funding over the last few years – what is the target population definition being used for the MHSA?
- Could you make Mark Raggins' documents on recovery available on the website?
- Is state mental health planning to make county mental health serve out-of-county foster youth?
- Where can I find a formal description of the System of Care Model?